VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

June 4, 2012

Ms. Lisa Bohlman, Administrator
Derby Green Nursing Home
PO Box 24
Derby, VT 05829

Provider #: 475048

Dear Ms. Bohlman:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **April 25, 2012**. Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN, MS
Licensing Chief

PC:ne

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/10/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475048	A. BUILDING _____ B. WING _____	04/25/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY GREEN NURSING HOME	2853 US ROUTE 5 DERBY, VT 05829

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced on-site annual recertification survey was conducted by the Division of Licensing and Protection from 4/23/12 - 4/25/12. The following regulatory violations were identified.	F 000	Derby Green provides this plan of correction without admitting or denying the validity or existence of the alleged deficiencies. The Plan of Correction is prepared and executed soley because it is required by federal and state law.	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assist 2 residents of the sample group (Residents #3 & #5) to maintain and enhance their dignity by failing to address issues of privacy and dignity regarding the social relationship/interactions between the two residents. Findings include: 1. Per observation on 4/23/12 at 1:29 P.M. Residents #3 & #5 were sitting in the facility's TV room/sun room with 2 other residents present. Resident #5 was observed putting his/her left hand on Resident #3's inner thigh and crotch, then cupping Resident #3's right breast in his/her right hand. After witnessing this, the surveyor conducted a staff interview with a Registered Nurse on the residents' unit. The Registered Nurse, when asked if staff was aware of the physical nature of Resident #3 & #5's interactions, stated h/she didn't see it but "I knew what you were talking about before you asked".	F 241	F241 The regulation on dignity was reviewed with staff at a full staff meeting on 5/14/12. Staff that was questioned by the surveyor during the annual survey, 4/23/12-4/25/12, answered to the surveyor, "that they would ask resident #3 and #5 to go to a private room if they were found touching each other." All staff at the full staff meeting was instructed to do the same if they found resident #3 and #5 in that position. Charge Nurses, DON and ADM monitor daily that these two residents are provided privacy when found in this position. All other residents will be provided with privacy if they show public displays of affection. The Charge Nurse, DON and ADM will monitor for this behavior ongoing. The care plans of #3 and #5, under the problem of cognitive loss, was updated with the intervention of "provide reassurance, redirect resident to private area if participating in acts of physical affection this is more than holding hands and/or brief kissing in public areas (Has established relationship with other resident.)	5/14/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lisa Robinson TITLE: Administrator (X6) DATE: 5/16/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241	Continued From page 1 Per interview with the facility's Administrator (ADM) and the Director of Nursing Services (DNS) at 5:16 P.M. on 4/23/12 both residents' families were contacted separately by the ADM and notified of the situation/behavior of the 2 residents, and both residents' families had signed "Love, Affection and Intimacy" forms. The ADM confirmed Resident #3 and Resident #5's displays of affection and intimacy have been witnessed with and without other residents present, and their intimate interactions take place in common areas of the facility where privacy and dignity would be an issue. During interview, on the afternoon of 4/25/12, the DNS confirmed the lack of care planning to address the issue of the relationship and intimate interactions for both residents.	F 241	F241 POC accepted 6/4/12 PMcotaRN	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under	F 279	F279 The care plans of #3 and #5, under the problem of cognitive loss, was updated with the intervention of "provide reassurance, redirect resident to private area if participating in acts of physical affection this is more than holding hands and/or brief kissing in public areas (Has established relationship with other resident.) The care plans will be reviewed quarterly by the interdisciplinary team and will be adjusted earlier if needed by the DON or ADM. F279 POC accepted 6/4/12 PMcotaRN	4/25/12

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F 279	Continued From page 2 §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to develop care plans to reflect the issue of privacy/dignity related to the social relationship/interactions between 2 applicable residents in the sample. (Residents #3 and #5). Findings include: Per record review, the care plans for Residents #3 and #5, both with cognitive impairment issues, did not address the issue of privacy and dignity during intimate interactions between the residents. Although the responsible parties for both residents had signed "Love, Affection and Intimacy" forms for each of the respective residents, in September of 2005, neither of their respective care plans addressed measurable goals or interventions to assure privacy and dignity were maintained during displays of affection and intimacy between the residents. Per observation, on the afternoon of 4/23/12, a surveyor witnessed intimate interactions between the residents who were sitting together on a couch in a common area in full view of other residents, staff and visitors. During interview, on the afternoon of 4/25/12, the DNS confirmed the lack of care planning, to address the issue of the relationship and intimate interactions, for both residents.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged	F 280		

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F 280	Continued From page 3 incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based upon staff interview and record review the facility failed to revise the plan of care and treatment for one resident of the sample group (Resident #10) to reflect when the condition of a wound deteriorated. Findings include: 1. Per record review, Nursing Notes for Resident #10 on 2/20/12 regarding h/her skin state: "open area coccyx...no signs or symptoms of infection". On 3/2/12 the plan of care for Impaired Skin Integrity for Resident #10 includes "Assess for signs and symptoms of infection. Revise care plan approaches if wound worsens". Per review of information from "Wound Care	F 280	F280 On 3/2/12 the TCP stated to assess for s/s of infection revise care plan approaches if wound worsens. The nurses continued to assess for infection. On Sunday, 3/11/12 at 0331 the nurse notes "exudates purulent, large amount, foul odor, peripheral skin edema." Again on 3/11/12 at 2140 the nurse notes "surrounding skin bright red, peripheral tissue edema and foul odor." On Monday, 3/12/12 at 0900 fax sent to attending physician by DNS. No new orders received and physician replied "will be in this week." At time of survey and presently the care plan reflects the current status of the wound. Per CMS regulation F280 Right to participate planning care- revise CP (iii) periodically reviewed and revised by a team of qualified persons after each assessment. The regulation will continued to be followed and the care plan of each individual resident will be periodically reviewed and revised by a team of qualified persons. The interdisciplinary team will review quarterly. Charge Nurse's, DNS and/or ADM will monitor that care plans are revised to reflect status of all wounds. F280 POC accepted 6/4/12 PMcotaRN	6/25/12

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F 280	Continued From page 4 Essentials: Practice Principles"*, "Early identification of wound infection is crucial in wound management...[the] clinical signs and symptoms of infection...cellulitis, malodor, pain, delayed healing, wound deterioration or breakdown, and an increased amount of exudate [a fluid that oozes out of blood vessels due to inflammation] are common to all [infected] wounds." Per record review, Nursing Notes from 3/11/12 state: "exudate purulent [containing or composed of pus] large amount, foul odor, peripheral skin edema." Per record review, Nursing Notes on 3/12/12 state: "Fax sent to attending [physician] -wound-requested assessment due to questionable wound healing. MD visiting later this week." Nursing Notes on 3/13/12 state: "open area Left upper buttock, foul slough odor, surrounding [tissue] bright red". Nursing Notes on 3/15/12 the open area on Resident #10's coccyx has "exudate copious, foul odor, wound bed green spongy. Surrounding [tissue] red and inflamed." Per interview with the Director of Nursing Services (DNS) on 9:45 A.M. 4/25/12 h/she confirmed Nursing Notes demonstrated a worsening of Resident #10's wound. The DNS stated they were following physician's orders and Resident #10's plan of care. The DNS confirmed Resident #10's plan of care stated "assess for signs and symptoms of infection. Revise care plan approaches if wound worsens." The DNS confirmed Nursing Notes demonstrated a worsening of Resident #10's wound on h/her coccyx/buttocks, and confirmed there was no revision of care plan approaches regarding skin	F 280		

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F 280	Continued From page 5 integrity until the wound was infected and required antibiotic and debridement treatment. *Reference: Wound Care Essentials: Practice Principles, by Sharon Baranoski, Elizabeth A. Ayello pg. 99 Lippincott Williams & Wilkins, August 14, 2007	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based upon staff interview and record review the facility failed to assure one resident (Resident #10) of the sample group attained or maintained their highest practical physical, mental and psychosocial well-being by failing to evaluate the results of interventions to an open wound (non-pressure related) and revising the interventions as the condition of the wound deteriorated. Findings include: 1. Per record review, Nursing Notes for Resident #10 on 2/20/12 regarding h/her skin state: "open area coccyx...no signs or symptoms of infection". On 3/2/12 the plan of care for Impaired Skin Integrity for Resident #10 includes "Assess for signs and symptoms of infection. Revise care plan approaches if wound worsens".	F 309	F309 The attending physician was notified of the worsening wound on 3/12/12 and again on 3/14/12. The attending physician made a visit on 3/15/12, made the diagnosis of infected wound, new orders were received and the TCP was updated with the new interventions. Nurses will continue to assess wounds for delayed healing and notify MD, as needed, ongoing. DNS and/or ADM will continue to monitor and review nurse's notes weekly. F309 POC accepted 6/4/12 PM return	4/25/12

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F 309	Continued From page 6 Per review of information from "Wound Care Essentials: Practice Principles™", "Early identification of wound infection is crucial in wound management...[the] clinical signs and symptoms of infection...cellulitis, malodor, pain, delayed healing, wound deterioration or breakdown, and an increased amount of exudate [a fluid that oozes out of blood vessels due to inflammation] are common to all [infected] wounds." Per record review, Nursing Notes from 3/11/12 state: "exudate purulent [containing or composed of pus] large amount, foul odor, peripheral skin edema." Per record review, Nursing Notes on 3/12/12 state: "Fax sent to attending [physician] -wound-requested assessment due to questionable wound healing. MD visiting later this week." Nursing Notes on 3/13/12 state: "open area Left upper buttock, foul slough odor, surrounding [tissue] bright red". Nursing Notes on 3/15/12 the open area on Resident #10's coccyx has "exudate copious, foul odor, wound bed green spongy. Surrounding [tissue] red and inflamed." Per interview with the Director of Nursing Services (DNS) on 9:45 A.M. 4/25/12 h/she confirmed Nursing Notes demonstrated a worsening of Resident #10's wound. The DNS stated they were following physician's orders and Resident #10's plan of care. The DNS confirmed Resident #10's plan of care stated "assess for signs and symptoms of infection. Revise care plan approaches if wound worsens." The DNS confirmed Nursing Notes demonstrated a worsening of Resident #10's wound on h/her	F 309		

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F 309	Continued From page 7 coccyx/buttocks, and confirmed there was no revision of care plan approaches regarding skin integrity until the wound was infected and required antibiotic and debridement treatment. *Reference: Wound Care Essentials: Practice Principles, by Sharon Baranoski, Elizabeth A. Ayello pg. 99 Lippincott Williams & Wilkins, August 14, 2007	F 309		
F 356 SS=B	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.	F 356	F356 On 4/25/12 the ADM and DNS permanently affixed a white board to the nurse's station wall with the following required information: facility name, current date, total number and actual hours worked by the following categories of direct care staff and resident census. This information is transferred every shift to the pre-existing staffing binder that is located at the nurse's station that is available for visitor and resident review. This will continue to be our process. All deficiencies listed will be brought to the next QA committee meeting and will be discussed and reviewed. F356 POC accepted 6/4/12 PMcclaRN	4/25/12

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F 356	Continued From page 8 The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and confirmed through staff interview the facility failed to post nurse staffing information in a prominent place readily accessible to residents and visitors. Findings include: Per observation, the posted information regarding nurse staffing did not include: the facility name, date and total number and actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift. This was confirmed by the DNS on the afternoon of 4/25/12.	F 356		